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CHECK-IN GROUPS: A NOVEL STRUCTURED CRISIS INTERVENTION MODEL

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Abstract: *Crisis intervention teams, task forces, and healthcare coalitions are not new concepts. For over 20 years, the State of Indiana has had an operational model of statewide emotional support and intervention teams which can be deployed to crisis events, consisting of volunteer professionals from various mental health and crisis intervention backgrounds. Traditionally, team interactions and "callouts" (state deployment of teams) to crisis events in the field have been face-to-face or, less commonly, via telephone. In March 2020, amidst the early onset of COVID-19, the largest state team, encompassing the county of the state capital and the surrounding seven counties, was activated to organize the provision of emotional and psychological support to a variety of individuals within essential and first responder organizations in Indiana. The original district team was expanded into a task force, consisting of key public and private stakeholders, in order to fulfill the seven missions issued from the state in the first two quarters of COVID-19. All the missions were delivered using virtual methods and utilized variations of evidence-informed intervention models and techniques. The COVID-19 pandemic launched extraordinary cooperation between 25 state and local agencies, hundreds of volunteers, and made available interventions to thousands of state citizens and public servants with two goals: keep people healthy and in service. Daily virtual meetings and virtual Just in Time Trainings were utilized to quickly implement training of interventions and new conceptual models of care; "check-in groups." The news and impact of the check-in groups model was growing, and additional agencies/organizations expressed interest to implement emotional support programming for their employees. The feedback from organizations, stakeholders, and team members provides some preliminary qualitative data of favorable impact of the "check-in groups" model for community or organizational-based crisis intervention and emotional support. This was a pilot program developed and implemented during an active pandemic event with the limitation of evaluation and assessment-planning being prioritized after initial implementation. Collective local and state teams are committed to and interested in continued efforts to evaluate the model's effectiveness. This will help propel progress forward in the evaluation of future missions and upcoming challenges associated with the COVID-19 pandemic, financial crisis, civil unrest, and other known and yet to come critical incidents.*

Key Words: *crisis intervention, emotional/peer/support groups, critical incident stress, wellness, resilience*

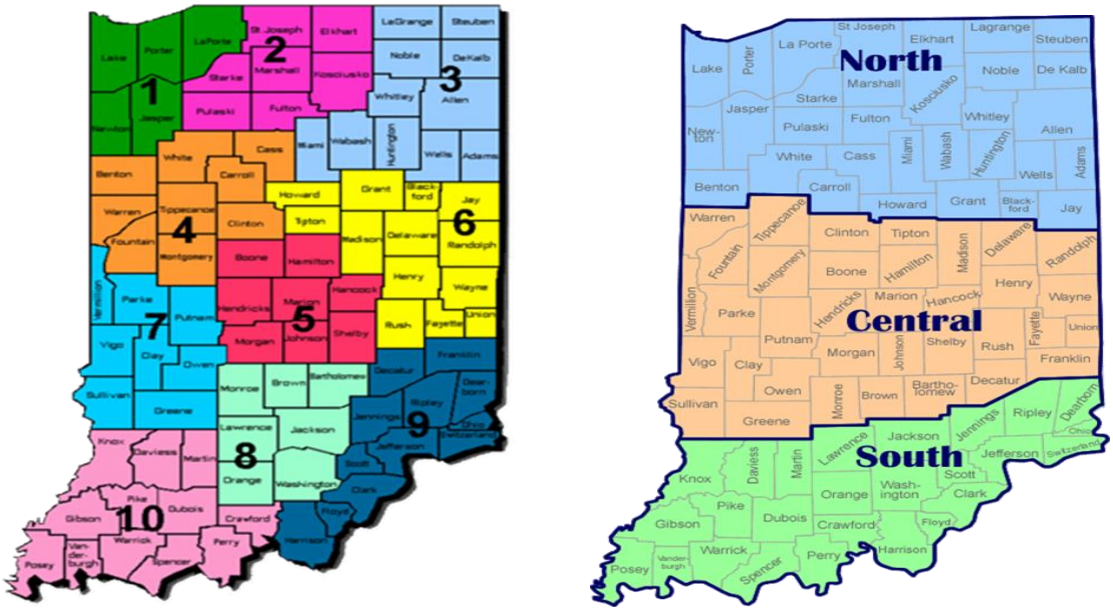
Background

Prior to, but especially since, Hurricane Katrina in 2005, the State of Indiana had a developed and functional mental health crisis intervention task force that was led via the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA). Preparedness plans ultimately would provide scalable and modulated teams embedded within the Medical Reserve Corps of the Indiana Department of Homeland Security's 10 state districts. Each district's emergency management strategy includes a behavioral health team of crisis intervention professionals called the Resilience and Emotional Support Team (REST Team). There was listed criteria for team membership and each team's coordinators reported up to the DMHA.

Figure 1

For many years, DMHA had designated one staff member's entire role as managing the REST Teams along with suicide awareness/intervention/prevention programs. Since 2014, the responsibility of leading the REST Teams was separated from the work on suicide awareness/intervention/prevention programs and was assigned to the responsibilities of a bureau chief. During this time, several of the 10 district teams continued to meet and drill regularly while other teams met irregularly or simply no longer met as an intact district team. Circumstances were that Indiana's District 5 REST Team, which includes Marion County (Indianapolis) and the surrounding seven counties, remained active and intact. And it was on Monday, March 16, 2020 that the District 5 Team became activated for the most intensive and longest missions of its existence.

Figure 2



COVID-19 Pandemic and Community Needs

On March 6, 2020, the very first COVID-19 positive patient in the State of Indiana was admitted to Community Health Network's North Hospital, located in Indianapolis. For several weeks prior to that admission, several state agencies' staff were experiencing an increase in stress related symptoms (anxiety, fatigue, and depression, per supervisor reports) and leadership of the agencies contacted DMHA for assistance with emotional support. DMHA made the determination to activate the District 5 REST Team (D5). The first D5 task force meeting was arranged for March 16, 2020 and the weekend prior was spent inviting individuals, agency heads, and organizations to attend the meeting on the following Monday morning.

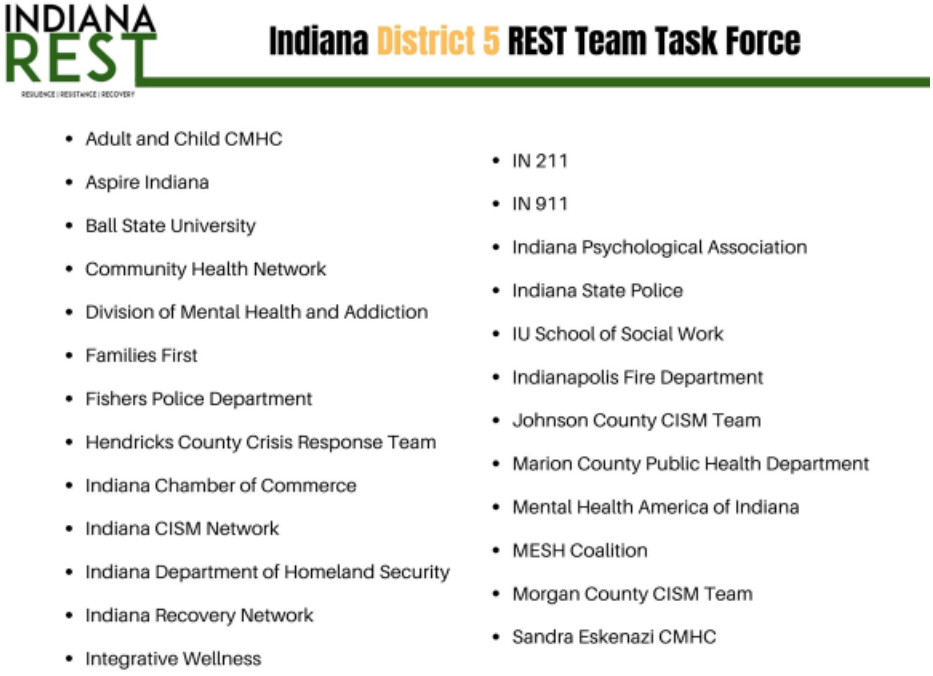
Table 1: Examples of common requests for support

- Feeling overwhelmed and/or anxious
- Social isolation
- Increased workload and/or responsibilities
- Fear of the unknown
- Fear of contracting COVID-19 or giving it to someone
- Caring for victims of COVID-19
- Financial concerns
- Lack of coping skills
- Domestic violence and/or personally threatening situations
- Civil unrest and protests

During the weekend of March 14-15, 2020, the D5 coordinator sent a callout to the D5 team asking who would be available for a series of missions to support state agency personnel. Sensing that more team members would be needed than were available from the original D5 team, the broader, expanded task force was invited. During that weekend and throughout the first two months, many offers to assist the D5 team came unsolicited and were gladly accepted, especially if the personnel, agency, or organization was known to one of the District 5 team members. In less than two weeks, a task force of 25 local and state agencies was assembled. One or two

representatives from each agency or organization was invited to attend the daily (virtual) meetings.

Figure 3



At the orientation meeting on March 16, 2020, it was decided that the team would host a daily briefing beginning at 9:15 a.m. The start time was adjusted from 9:00 a.m. because the virtual platform (initially GoToMeeting) was "crashing" on the hour with so many people logging on for meetings at that time. These morning briefings, lasting no more than one hour, would continue Monday through Friday for four weeks, followed by twice weekly briefings (Tuesdays and Thursdays) for seven weeks. Once weekly briefings (Thursdays) followed for five weeks and became every two weeks until eventually becoming monthly briefings beginning in September 2020.

From March through November 2020, the D5 team was assigned a total of seven missions to offer emotional support, education, and referral information. The D5 team leadership purposefully used the term "mission" to indicate a combination of definitions as "a specific task with which a person or a group is charged" and "a calling or vocation." (Merriam-Webster. (n.d.)). The agencies requesting and receiving support from the D5 team were, in order of team interventions, Indiana 211 Call Center (IN 211), Indiana State Department of Health, Indiana 911 Call Centers and any law enforcement, fire, and EMS professional in the state of Indiana, Indiana Department of Workforce Development, Indiana Department of Correction, Indiana Department of Transportation, and the Indiana Hospital Association. As of December 2020, only the Indiana Department of Correction had an active mission. All other interventions have been completed.

Before the pandemic, membership on the D5 team was stated in DMHA directives and membership criteria is listed in Table 2. D5 team membership and participation criteria has been expanded and relaxed since March 2020. These criteria will be revisited and potentially revised once the missions have ceased and there is a period of reprieve.

Table 2 REST Team Membership (prior to March 2020)

- licensed by the Behavioral Health and Human Services, Psychology, Medical, or Nursing board, *and*
- master's degree
  - 2 years providing mental health services, *or*
- bachelor's degree
  - 2 years providing mental health services and demonstrated knowledge of trauma-informed care, *or*
  - 1 year of experience providing case management services and demonstrated knowledge of trauma-informed care, *or*
- Yoga Alliance registration and RYT 200 and/or RYT 500 credential, *or*
- current involvement or registration with DMHA teams, *or*
- spiritual leader with a terminal degree or ecclesiastical ordination

In addition, team members are asked to become trained in National Incident Management System (Dorn 2005; National Incident Management System (NIMS) 2017), Psychological Simple Triage and Rapid Treatment (Schreiber, et al. 2014), Psychological First Aid (Brymer, et al. 2006; Brymer, et al. 2005; Center for the Study of Traumatic Stress 2006; Florida Center for Public Health Preparedness 2005 and 2006; Johns Hopkins Center for Public Health Preparedness 2006; Schreiber et al., 2006; Shultz & Forbes 2014; Substance Abuse and Mental Health Services Administration (SAMHSA) 2005), Critical Incident Stress Management (Everly 2016; Every & Mitchell 2008; Mitchell 2020; Mitchell & Everly 2000), American Red Cross Disaster Mental Health (North et al. 2000), or other approved crisis intervention models.

The D5 team serves a variety of functions to Indiana citizens, family members, and first responders. The overall mission of the Indiana REST Teams is to coordinate all mental health and addiction activities prior to, during, and after an emergency or disaster, including acts of terrorism.

Table 3: D5 REST Team Provides

- Early psychological intervention
- Psychological First Aid
- PsySTART (Psychological Simple Triage and Rapid Treatment)
- Responder resilience training and support
- Stress management and support
- Critical Incident Stress Management
- Emotional and spiritual care
- Referrals to resources for ongoing behavioral health treatment or social service needs

The initial D5 team support went to the Indiana 211 Call Center (IN 211) whose staff provides referral and resource information previously handled by the 411 call center system. Prior to March 2020, the call center staff (approximately 29 people) had been working onsite and were answering approximately 1,500-2,000 calls per day. Beginning in March, staff were asked to work remotely (i.e. from home) and began receiving calls that were for emotional support in addition to their regular calls for information, resources, and referrals. Calls requiring emotional support and referrals for behavioral health concerns was not something IN 211 staff had been specially trained to do. During the early days of the pandemic in Indiana, the IN 211 Call Center volume reached 25,000 calls per day. Fearing staff would suffer from burnout, absenteeism, or worse, quit, IN 211 leadership requested support from the D5 team.

The D5 team immediately accepted the mission and in less than two weeks had devised an intervention strategy, arranged Just in Time Trainings for the volunteer facilitators, scheduled twice weekly supervision meetings for volunteers, and provided logistical consultation to IN 211 leadership.

Check-In Group Model

Understanding the benefits of group support, the D5 team believed that a type of small group support would serve the most staff in the most efficacious manner (Mitchell 2015; Yalom & Leszcz, 2005).

Many D5 team members have been trained in Critical Incident Stress Management (CISM) (Mitchell 2020) so there was a good base of knowledge about providing support to targeted groups. The D5 team also understood that the IN 211 staff likely would require ongoing and consistent support over time and developed what became dubbed as the "check-in group." The model was an amalgam of group models from counseling, psychotherapy, traditional support groups, Psychological First Aid, CISM debriefings, solution-focused brief therapy, and drop-in groups. It was believed the groups should be structured, short in duration, and small (between one and six participants). Adjustments and edits were made to an existing model that had been piloted at Community Health Network in 2019. Originally, the group check-in concept was created to assist unit nurses who were experiencing high levels of stress and compassion fatigue (Cocker & Joss 2016; Lombardo & Eyre 2011; Nolte et al., 2017). The idea was to bring nursing staff together at the end of each shift for a small huddle and ask a series of only three questions:

1. What was the most challenging case you had during your shift?
2. What was one thing about your shift you thought you did well or was rewarding?
3. What is one thing you will do to care for yourself between now and your next shift?

The questions were designed to be asked in order and without much discussion, not longer than 10 minutes for the entire group meeting time. The rationale for the first question was so individuals could begin to identify a stressful event or issue from their shift. The second question was designed to enhance self-efficacy by identifying something the person did well during that time. Question three asked the employee to identify at least one personal coping skill. Employees were encouraged to say the coping skill aloud to enhance personal accountability.

For the IN 211 staff, all three questions were adopted but amended to read:

1. What was the most challenging case/issue of your most recent shift?
2. What is one success that happened during that shift?
3. What is one thing you will do to take care of yourself in the next 12/24 hours?
4. What is one way you can support a colleague(s) in the next 12/24 hours?

During the D5 team meetings, it was suggested to add the fourth question listed above to the model that was intended to lend support to a colleague and enhance altruism and universality.

Next, it was recommended to utilize co-facilitators for the check-in model groups; one mental health professional paired with one peer professional who also would serve as a resource should issues of substance use become known or suspected.

One of the D5 task force member groups was the Indiana Association of Peer Recovery Support Specialists (formerly Indiana Recovery Network),which built and maintained statewide recovery resources for those seeking or who are in recovery from a substance use disorder. The Indiana Association of Peer Recovery Support Specialists offered access to a network of several hundred peer support professionals. After vetting the peer support and mental health facilitator volunteers, each were required to attend at least one of two 90 minute Just in Time Trainings about the check-in group model.

D5 team members advised the IN 211 leadership that small groups would be needed, and that no more than four to five staff should be in a group. All groups would have the same staff members for each group meeting and IN 211 leadership oversaw selecting which personnel would be assigned to each group. All staff would meet in the groups as part of their working day and would be compensated for attending. No one would be disciplined for not attending although it was strongly encouraged that the groups were designed to keep staff healthy and in service. Groups were identified by a color (blue, gray, green, orange, purple, red, and yellow).

Facilitators were paired together according to their schedules. Most co-facilitators did not know each other prior to starting the check-in groups. They were instructed to ask the four questions in order during each group meeting and to allow all members to answer question one before moving to question two, and so forth. It was up to the facilitators which one would ask the four questions (either one facilitator asking all the questions, taking turns, rotating across each meeting, or another combination). For most groups, the first check-in group meeting was used to orient the IN 211 staff to the concept of the model, to introduce the facilitators, introduce themselves to each other, to model answering the questions, and explain the rationale for the questions' order. A discussion about confidentiality and the limits of privacy was included both during the first check-in group meeting and in written correspondence with IN 211 leadership.

It was noted that although many of the mental health facilitators had doctoral degrees, not everyone had been trained in crisis intervention or Psychological First Aid. Therefore, a portion of the Just in Time Trainings was devoted to explaining or reviewing the differences between crisis intervention and group psychotherapy/counseling.

The model pivoted from being used at the end of a shift to the very beginning of a shift, when staff were more predictably available to begin at the same time. It was decided that each meeting would last no longer than 30 minutes, each group would have no more than five employees, and each group would meet twice a week either Monday/Wednesday or Tuesday/ Thursday. Because the IN 211 staff operated a 24/7 schedule, the start times for each group were made in consideration of staff schedules; either beginning at 8:00 a.m., 8:30 a.m., 1:30 p.m., or 5:00 p.m. Group member assignments would remain fixed thus increasing the opportunity for group familiarity, bonding, and cohesion. Consistent attendance was encouraged, and all staff members ended up attending the check-in groups. Although group members were informed that they were not required to speak, all staff ended up participating fairly equally.

Originally, the check-in groups were scheduled to last four weeks. By the end of the third week, all group members vocalized that the meetings were helpful, and they asked whether they could be continued for several more weeks. In consideration of this request, and to allow time for the facilitators to adjust their personal schedules to accommodate the additional groups, a one-week reprieve was initiated during week five. Also, during week five, three D5 team members designed and offered IN 211 staff the option of attending one of two 90-minute discussions on resilience, which included a Power Point presentation and accompanying workbook. Following that, two additional weeks of twice weekly check-in group meetings were added. IN 211 leadership reported that the check-in groups helped decrease staff anxiety, increase resilience, and stave off a mass staff exodus. All group check-in meetings and the resiliency presentations were done using the Zoom virtual meeting platform.

In addition to the initial mission with the IN 211 staff, six additional D5 team missions ensued, each with a unique combination of support, interventions, volunteer base, virtual platform, and dedicated D5 team member(s) (see Supplemental Information, Figures 1-8). After learning about the check-in group model, the Indiana Hospital Association (Mission 7) initiated a pilot project for healthcare executives whose organizations were members of the association. Their targeted population came from executives from around the state who randomly were placed in small groups with other executives who had similar group start time requests. The success of their pilot project has turned into an opportunity to promote the model on a larger scale within the Indiana Hospital Association organization. Executives reported feeling heard, that the check-in groups provided a safe environment to share concerns, and that they learned coping tools. Some groups planned to continue meeting on their own and beyond the pilot end time.

Community Crisis Team: Lessons Learned

The D5 team hope that other healthcare coalitions, crisis intervention teams, and volunteers will benefit from our "lessons learned." Ten lessons seemed most salient.

1. Connect with people you trust. Work in crisis intervention can be rapid and even relentless. Although differences of opinion were easily shared during daily meetings, outright conflict and personality clashes were amazingly absent. Leaders are advised to include teammates who can be trusted, will be confidential, and have the ability to make rational and quick decisions.
2. Have a pioneering attitude. In March 2020, the pandemic came to Indiana and our team ventured into the unknown. We did not understand the virus, what was going to happen to our lives, to the world, to our jobs, to our loved ones, and on and on. And yet, you want team members who will embrace novelty, the untested, or in other words, the unknown. Despite the early fears, the overall sense of the D5 team was, "We can do this!" Literally, no one ever said 'no.' The positive mind set propelled and buoyed the group throughout the missions.
3. Base decisions on science and best practice. It's imperative that your team have a good basis of training in crisis theory, early psychological intervention, communication skills, and a good mix of individual and group models of support. Once the team understands the basics of crisis intervention, they can pivot, adapt, or amend as indicated.
4. Make stuff up! Extraordinary circumstances call for rational as well as creative thinking. Our D5 team had never engaged in virtual support, been tasked with performing more than one mission at a time, had overlapping missions, or stood up interventions beyond one month. During our morning task force meetings, we had brain storming sessions and if an idea seemed reasonable, we went with it. It wasn't, "Can we do that?" but more so, "OK, let's do it!"
5. Make data collection part of your task force process. Thinking about and collecting data can be challenging during crises. But it is exactly during these times when gathering

information and facts is important. Conversations about assessment tools, survey types, research interventions, internal review boards, etc. can be done prior to team mission activations. Data collection can be a routine part of your preparedness and drills. In fact, data was collected during the IN 211 and Indiana Hospital Association missions, however it is being analyzed and was not available at the date of this submission.

6. Change and go. Making decisions quickly and then moving forward was crucial to the success of the team. Normally, our team will aim for consensus, work methodically, and carry over items from meeting to meeting if they cannot be easily resolved. During the initial months of the pandemic, the team made process or intervention changes very quickly, sometimes within minutes. And once a change was made, we did not discuss it or focus on it.
7. Expect to get "crusty" and "crushed." Even the most even-tempered crisis intervention veteran will become fatigued during a mission. Part of the leadership's role is to monitor team members for proper sleep, nutrition, cognition, and attitude. We must feel free to encourage or even confront each other when someone could use a break (even for a few hours or days). And even though the D5 team was motivated, cohesive, and had little to no conflict, we did run into unforeseen circumstances when something or someone could have crushed the team's spirit. It's important that team leaders run interference so as not to distract the group's forward movement or focus.
8. Have hard starts and stops. In a crisis, it can be difficult to know exactly when to begin a new intervention or how quickly to schedule new trainings. And doing this with brand new platforms, processes, and structures can be overwhelming. The D5 team found that simply selecting a start time and sticking with it was a good strategy. Often this was done with four- or five-days lead time, which at the beginning of the pandemic, seemed unfathomable. Prior to March 2020, decisions to quickly intervene could happen easily but the intervention models were already known and well-rehearsed. The D5 team's activation and all seven missions were brand new. Prior to March 2020, if the team participated in a table-top drill and was told that all interventions would be virtual and perhaps novel, we would have estimated interventions would take several weeks to months to implement. Now we understand that's not necessarily true. Setting arbitrary start dates literally forced the team to work quickly and nimbly. Granted, this resulted in smaller groups working together anywhere from 10 to18-hour days for days in a row, but the work was always completed on time and no interventions were ever rescheduled based on the D5 team's request. At the same time, putting a formal stop to a mission was important because it allowed the team to pivot and move on. The team had an opportunity to formally thank the many volunteers involved in a mission and it put closure to the original request for support. The team always indicated that it would be happy to revisit a request of support, as needed.
9. Thank you. Thank you. Thank you. There was not a meeting, a phone call, a group, or individual discussion that didn't end with thanks. This was said verbally, in texts, and via emails. Even though many D5 team members were working together (virtually) for hours per day, we continued to thank each other for the demonstrated commitment and dedication.
10. Self and Team Care. Often, especially for leadership, self-care can take a back seat to the mission at hand. And frankly, it did for several of D5 team members. As the team coordinator, I set the agenda for and led the team meetings. I also agreed to take the meeting minutes, which I typed and sent out to the team by beginning of the next meeting. This freed up other team members to work on surveys, data collection, and create documents for often overlapping missions. Still, the D5 duties were in addition to task force members' regular jobs and accompanying life and family changes brought about by the pandemic (i.e. such as having school-aged children learning from home). Many team members were working on our missions for 10 to18-hours a day (including weekends) for weeks and months. Prior to the pandemic, I had agreed to give a lecture to a local university's graduate Counseling students about state licensure laws. With the activation of the D5 team, I didn't feel I had the time to give the presentation but wanted to honor the commitment. At the end of the 90-minute

(virtual) presentation, I told the class (all young adults in their early to mid-20's) to "stay safe" and as soon as I said that I started crying and it took me a few seconds to regain my composure. Afterward, I told the class that I hadn't realized how stressful the previous few weeks had been, that I hadn't had much sleep in almost a month, and that my own 25-year-old daughter had been very ill for over three weeks (presumably with COVID-19). It is unusual for me to cry in public and it was a wake-up call to practice the self-care our team had been preaching. The following morning during the D5 team call, I mentioned the incident and asked whether anyone else was experiencing similar signs of stress. After hearing several yeses, a routine part of the morning meetings focused on self-care. Team members were encouraged to say aloud what they were doing to care for themselves, and this allowed for accountability (exactly the rationale for question number 3 in the group check-in model).

Beginning in November 2020, Community Health Network, one of four large healthcare organizations in central Indiana, will begin trials of the group check-in model to support its staff (front-line and otherwise) who are combating both the flu season and the surge of COVID-19 positive patients. In addition to other reports of healthcare support (Albott, et al. 2020; Edrees et al. 2016; Feinstein, et al. 2020; Gonzalez, et al. 2020; Miotto, et al. 2020; Shechter, et al. 2020; and Sockalingam, et al. 2020) network leaders from a variety of departments (including the internal peer support team, Employee Assistance Program, Behavioral Health, Chaplaincy, Physician Well-being, and Academic Affairs) enthusiastically embraced the check-in group model. The network believed their own internal staff could act as facilitators but consultation with D5 team leaders would be helpful. Engaging in data collection on the model's effectiveness is expected.

The D5 team has one active mission as of December 11, 2020. While we anticipate a successful completion of the one remaining mission, we anticipate being reactivated for additional requests of support as we face the winter season, the flu, the current, increasing numbers of COVID-19 positive people, and the unknown. We are ready.

References

Albott, C. S., Wozniak, J. R., McGlinch, B. P., Wall, M. H., & Gold, B. S. (2020). Battle buddies: Rapid deployment of a psychological resilience intervention for health care workers during the COVID-19 pandemic. *Anesthesia and Analgesia*, *131*(1): 43-54.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2005). *Psychological First Aid: Field operations guide.* National Center for PTSD and National Child Traumatic Stress Network, UCLA.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., and Watson, P. (2006). *Psychological First Aid: Field operations guide, 2nd Edition.* National Center for PTSD and National Child Traumatic Stress Network, UCLA. http://www.nctsn.org/content/psychological-first-aid.

Center for the Study of Traumatic Stress. (2006). *Psychological First Aid: How you can Support well-being in disaster victims.* Disaster Response Education and Training Project, Center for the Study of Traumatic Stress. http://www.cstsonline.org/psychological-first-aid/.

Cocker, F., & Joss, N. (2016). Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review. *International Journal of Environmental Research and Public Health*, *13*(6), 618. https://doi.org/10.3390/ijerph13060618

Dorn, R. R. (2005). Introduction to the National Incident Management System (ICS): What it means to you. *Sheriff*, *57*(3), 58, 60, 65.

Edrees, H., Connors, C., & Paine L., Norvell, M., Taylor, H., & Wu, A. (2016). Implementing the RISE second victim support programme at the Johns Hopkins Hospital: A case study. *BMJ Open*, *6*(9), **:**e011708. 10.1136/bmjopen-2016-011708.

Everly, G. Jr. (2016). *Critical incident stress management: Assisting individuals in crisis*, (5th ed.). International Critical Incident Stress Foundation.

Everly, G., Jr. & Mitchell, J. (2008). *Innovations in disaster & trauma psychology: Integrative crisis intervention and disaster mental health*. (Vol. 4). Chevron Publishing Corporation.

Feinstein, R. E., Kotara, S., Jones, B., Shanor, D., Nemeroff, C. B. (2020). A healthcare workers mental health crisis line in the age of COVID-19. *Depression and Anxiety*, *37*(8), 822-826.

Florida Center for Public Health Preparedness. (2005). *B-FAST: Disaster behavioral health first aid specialist training.* University of South Florida, http://www.fcphp.usf.edu/courselistings/courses_ListingsBFAST.htm.

Florida Center for Public Health Preparedness. (2006). *C-FAST: Disaster behavioral health first aid specialist training with children.* University of South Florida. http://www.fcphp.usf.edu/courselistings/courses_ListingsCFAST.htm.

Gonzalez, A., Cervoni, C., Lochner, M., Marangio, J., Stanley, C., & Marriott, S. (2020). Supporting health care workers during the COVID-19 pandemic: Mental health support initiatives and lessons learned from an academic medical center. *Psychological Trauma: Theory, research, practice, and policy, 12*(S1), S168-S170.

Johns Hopkins Center for Public Health Preparedness. (2006). *Psychological First Aid competencies for public health workers.* Johns Hopkins University. http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/online/dis_mtl_hlth_comp.html.

Lombardo, B., Eyre, C., (2011) Compassion Fatigue: A nurse's primer *The Online Journal of Issues in Nursing*, *16*(1), Manuscript 3. https://DOI: 10.3912/OJIN.Vol16No01Man03

Merriam-Webster. (n.d.). Mission. In *Merriam-Webster.com dictionary*. https://www.merriam-webster.com/dictionary/mission

Miotto, K., Stanford, J., Brymer, M., Bursch, B., & Pynoos, R. (2020). Implementing an emotional support and mental health response plan for healthcare workers during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S165-S167.

Mitchell, J. (2015). *Critical incident stress management: Group crisis intervention,* (5th ed.). International Critical Incident Stress Foundation.

Mitchell, J. (2020). Critical incident stress management: A comprehensive, integrative, systematic, and multi-component program for supporting first responder psychological health. In C. A. Bowers, D. C. Beidel, & M. R. Marks (Eds.). *Mental health intervention and treatment of first responders and emergency workers* (pp. 103-129). IGI Global.

Mitchell, J. & Everly, G., Jr. (2000). Critical incident stress management and critical incident stress debriefings: Evolutions, effects, and outcomes. In B. Raphael & J. Wilson (Eds.), *Psychological debriefing: Theory, practice, evidence* (pp. 71-90). Cambridge University Press.

National Incident Management System (NIMS) (2017). Federal Emergency Management Agency. http://www.fema.gov, https://www.hsdl.org/?view&did=804929

Nolte, A., Downing, C., Temane, A., Hastings-Tolsma, M. (2017). Compassion fatigue in nurses: A metasynthesis. *Journal of Clinical Nursing*, *26*(23-24), 4364-4378. https://doi.org/10.1111/jocn.13766

North, C. S., Weaver, J. D., Dingman, R. L., Morgan, J., & Hong, B. (2000). The American Red Cross Disaster Mental Health Services: Development of a cooperative, single function, multi-disciplinary service model. *The Journal of Behavioral Health Services & Research, 27***,** 314–320. https://doi.org/10.1007/BF02291742

Schreiber, M., Gurwitch, M., & Wong, M. (2006). *Listen, protect, connect.* The Advertising Council, US Department of Homeland Security, The National Center for School Crisis and Bereavement. www.ready.gov .

Schreiber, M., Shields, S., Formanski, S, Cohen J., & Sims, L. (2014). Code Triage: Integrating the national children's disaster mental health concept of operations across health care systems. *Clinical Pediatric Emergency Medicine*, *15*(4), 323-333. DOI: 10.1016/j.cpem.2014.09.002

Shechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., Birk, J., Brodie, D., Cannone, D. E., Chang, B., Claassen, J., Cornelius, T., Derby, L., Dong, M., Givens, R., Hockman, B., Homma, S., Kronish, I., Lee, S….Abdalla, M. (2020). Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. *General Hospital Psychiatry*, *66*, 1-8.

Shultz, J. & Forbes, D. (2014). Psychological First Aid: Rapid proliferation and the search for evidence. *Disaster Health*, *2*(1), 3–12. https://doi: 10.4161/dish.26006

Sockalingam, S., Clarkin, C., Serhal, E., Pereira, C., & Crawford, A. (2020). Responding to health care professionals' mental health needs during COVID-19 through the rapid implementation of Project ECHO. *Journal of Continuing Education in the Health Professions*, 40(3),

211-214. doi: 10.1097/CEH.0000000000000311

Substance Abuse and Mental Health Services Administration (SAMHSA). (2005). *Psychological First Aid – A guide for emergency and disaster response workers (fact sheet).* US Department of Health and Human Services, http://store.samhsa.gov/product/Psychological-First-Aid-for-First-Responders/NMH05-0210.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. Basic Books.

Supplemental Information

Figure 1

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
1	IN 211	4/6/2020 5/4/2020	5/1/2020 5/21/2020	PHASE I • Shift check-in with small groups and co-facilitators (MHP + Peer) • Meeting M-F 2X per week for approx. 30 minutes • Resiliency training PHASE II • One-week reprieve/staff to complete Resiliency workbook • Weekly coaching on peer-lead weekly shift check-ins • Complete an individual staff self-survey	Zoom	Just in Time Trainings: 2 Weekly Supervision: 2 X 30" Mission operation: Seven weeks Volunteers: 14 Volunteer hours: ~ 200

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Figure 2: District 5 REST Team Resource Guide.
Mission: COVID-19 Support

Shift Support

The primary mission is to provide acute, emotional care and support. We anticipate most check-ins will last between 15-30 minutes, depending on the number of participants and the issues they raise. During the initial support meeting, participants should be informed about confidentiality and its limits.

Introduction:

- D5 *("Hello, I'm _____, a member of the District 5 REST Team and a Mental Health Professional.").*
- D5 *("Hello, I'm _____, a member of the District 5 REST Team and a Peer Support Professional.").*
- 211 Call Center Staff will introduce themselves.

Shift Support Questions and Rationale:

The questions are simple to understand and designed to be answered quickly. They are asked strategically and in order so that individuals will begin to identify stressful event(s) or issue(s) from their shift. The second question is designed to enhance self-efficacy by identifying something the person did well during that time. Question three asks the employee to Identify at least one personal coping skill. Employees are encouraged to say this aloud whether speaking one-on-one with a support team member or whether in a group of their peers. This enhances personal accountability. The final question's answer is intended to convey support to a colleague and enhance altruism and universality. Team members will utilize crisis intervention skills including Psychological First Aid, Critical Incident Stress Management, and other intervention-related skills (such as NOVA training).
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"Indiana 211 Call Center staff, management, and the District 5 REST Team will team up for support, education, and information as we mitigate the effects of the COVID-19 pandemic. Our mission is to focus on emotional well-being and move toward keeping you healthy and in service. The meetings will not be psychotherapy sessions, but instead are designed to be touchpoints that promote self-care and teach positive coping strategies. Your feedback will help identify potential stressors, successes, coping skills, and wishes for your team.

Please know this is a confidential discussion. We've all been taught about needing to act on and report self-harm, harm to others, child or adult abuse, but otherwise, what you share specifically will not be reported to your manager. Because we want to make sure the meetings are helpful to you and to customize our resource recommendations, the facilitators will be taking notes on common themes, topics, and trends that the group discusses. None of the data being collected will be identifiable and your responses will be completely anonymous. Each week you will have an opportunity to complete a brief online survey about how you are doing. Informed consent will be explained each time you open the online survey. Finally, we will keep a list of your cell phone numbers in case we have a Zoom malfunction or if we need to contact you (to answer a question, for example). At the end of our month-long check in meetings, your contact information will be discarded."

Employees BEGINNING their shift:

What was the most challenging case/issue of your most recent shift?
Share one success that happened during that shift?
What is one thing you will do to take care of yourself in the next 12/24 hours?
What is one way you can support a colleague(s) in the next 12/24 hours?

Resource information:

• CDC	www.cdc.gov
• SAMHSA	www.samhsa.gov
• Indiana Center for PTSD	www.ncptsd.org
• Mental Health America of Indiana	www.mhai.net
• Division of Mental Health & Addiction	www.in.gov/fssa/dmha/index.htm
• Local Crisis Lines	(317) 880-8485 Sandra Eskenazi CMHC (317) 621-5700 Community Health Network
• National Suicide Prevention Hotline	(800) 273-8255 or (800) 273-TALK
• National Suicide Prevention Text line	Text IN to 741741
• Disaster Distress Helpline	(800) 985-5990
• Disaster Text line	Text "TalkWithUs" to 66746

Figure 3

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
2	Indiana State Department of Health	4/13/2020	5/15/202	PHASE I • CISM and PFA • Open phone line by MHPs • M-F 10am-2pm PHASE II • Individual staff self-survey* *Did not get completed	Phone line via 211	Just in Time Trainings: 2 Weekly Supervision: 2 X 30" Mission operation: 28 days Volunteers: 27 Volunteer hours: ~230

Figure 4

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
3	IN 911 & 1st Responders	4/22/2020	7/31/2020	• CISM and PFA • 7 days/week • 1:00pm-3:00pm and 6:00pm-8:00pm	Zoom and separate phone line for First Responders via 211. Changed to Webex only after three weeks	Just in Time Trainings: 4 Weekly Supervision: 2 X 30" Mission operation: 15 weeks Volunteers: 21 Volunteer hours: ~220

Figure 5

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
4	Indiana Department of Workforce Development	4/28/2020	5/15/2020	• CISM and PFA • Open phone line by MHPs • M-F 10am-2pm • Needs assessment sample questions • Resiliency training	Phone line via 211	Just in Time Trainings: 2 Weekly Supervision: 2 X 30" Mission operation: 14 days Volunteers: 27 Volunteer hours: ~30

Figure 6

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
5	Indiana Department of Correction	5/14/2020	TBD	• CISM and PFA • Shift check-in with small groups and co-facilitators • Meeting X per week for approx. 30 minutes • 1:1 support as requested • Resiliency videos • Use of internal CISM Team and separate support from area CMHCs	Webex and in person	Just in Time Trainings: 2 Weekly Supervision: 2 X 30" Mission operation: Volunteers: 3 Volunteer hours: TBD

Figure 7

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
6	Indiana Department of Transportation	5/14/2020 6/17/2020	5/14/2020 11/18/2020* *Re-Scheduled per request of INDOT	• Presentation: "Mental Health 101" • Presentation: "Mental Wellbeing & Resilience for Employees Working from Home"	Microsoft Teams	Just in Time Trainings: 0 Weekly Supervision: 0 Mission operation: 2 days Volunteers: 2 Volunteer hours: ~6

Figure 8

Mission #	Name	Start Date	End Date	Model(s)	Platform(s)	Stats
7	Indiana Hospital Association	8/3/2020 9/8/2020	8/27/2020 9/8/2020	PHASE I • Shift check-in with small groups and co-facilitators (MHP and/or Peer) • Meeting M-F 2X per week for approx. 30 minutes • Resiliency training PHASE II • 1 ½ week reprieve • Resiliency presentation • Complete an individual staff self-survey	Zoom	Just in Time Trainings: 2 Weekly Supervision: 4 X 30" Mission operation: Five weeks Volunteers: 10 Volunteer hours: ~80